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In the Supreme Court of the United States

OCTOBER TERM, 1992

GOOD SAMARITAN HOSPITAL, ET AL., PETITIONERS,

v.

DONNA E. SHALALA, PH.D., SECRETARY OF HEALTH AND HUMAN SERVICES, RESPONDENT.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

REPLY BRIEF FOR THE PETITIONERS

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TABLE OF CONTENTS

Introduction 1

A. The Secretary's Construction of Clause (ii) Is Strained 2

B. The Legislative History Does Not Support The Secretary's Interpretation 7

C. *Georgetown* Supports the Petitioners 11

D. The Secretary's Position Deserves No Deference 14

TABLE OF AUTHORITIES

CASES

Association of American Medical Colleges v. Califano, 569 F.2d 101 (D.C. Cir. 1977) 12

Bowen v. Georgetown University Hospital, 488 U.S. 204 (1988) ..... *passim*

Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984) 14

EEOC v. Arabian American Oil Co., 111 S. Ct. 1227 (1991) 15

EEOC v. Associated Dry Goods Corp., 449 U.S. 605 (1981) 14

FPC v. Texaco, Inc., 377 U.S. 33 (1964) 13

INS v. Cardoza-Fonseca, 480 U.S. 421 (1987) 14

Kingsbrook Jewish Medical Center v. Richardson, 486 F.2d 663 (2d Cir. 1973) 8

Morton v. Ruiz, 415 U.S. 199 (1974) 15

Mt. Sinai Hospital of Greater Miami, Inc. v. Weinberger, 376 F. Supp. 1099 (S.D. Fla. 1974), *rev'd*, 517 F.2d 329 (5th Cir. 1975), *cert. denied*, 425 U.S. 935 (1976) 14

National Muffler Dealers Association, Inc. v. U.S., 440 U.S. 472 (1979) 15
Pacific Gas & Electric Co. v. FPC, 500 F.2d 33 (D.C. Cir. 1974) 13
Pittston Coal Group v. Sebbin, 109 S. Ct. 414 (1988) . 14
Red Lion Broadcasting Co. v. FCC, 395 U.S. 367 (1969) 15
Southeastern Community College v. Davis, 442 U.S. 415 15
United States v. Storer Broadcasting Co., 351 U.S. 192 (1956) 13

STATUTES

42 U.S.C. § 1395g ..... *passim*
42 U.S.C. § 1395x(v) 2, 6
42 U.S.C. § 1395x(v)(1)(A) ..... *passim*
42 U.S.C. § 1395oo 12
42 U.S.C. § 1395oo(a) 10
42 U.S.C. § 1395oo(f)(1) 12
42 U.S.C. § 1395ww(b) 13
42 U.S.C. § 1395ww(d) 9, 13
42 U.S.C. § 1395yy(d) 13

LESISLATIVE MATERIALS

H.R. Rep. No. 231, 92d. Cong., 2d Sess. (1972), *reprinted in* 1972 U.S.C.C.A.N. 4989 10
S. Rep. No. 1230, 92d Cong., 2d Sess. (1972) 10, 11
Reimbursement Guidelines for Medicare: Hearing Before the Senate Comm. on Finance, 89th Cong., 2d. Sess. (1966) 7

MISCELLANEOUS

Provider Reimbursement Manual § 2405.1.B 9

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Introduction

In our opening brief, we showed that clause (ii), as this Court repeatedly ruled in *Georgetown*, requires a three-step process:

> (1) determine what amount is owed under the Secretary's regulations for a fiscal period—*i.e.*, "for any fiscal period, the aggregate reimbursement produced by the methods of determining costs";
>
> (2) determine whether that amount is too low or too high—"adequate or excessive," *i.e.*, less or more than the "reasonable cost," which is "the cost actually in-

curred, excluding therefrom any part of incurred costs found to be unnecessary in the efficient delivery of needed health services" (§ 1395x(v)(1)(A)); and

(3) adjust the amount paid (up or down) to eliminate the inadequacy or excess—*i.e.*, make "suitable retroactive corrective adjustments."

This is the plain, simple, and unambiguous meaning of clause (ii). It is precisely how this Court read clause (ii) four times in *Georgetown*. It is supported by the legislative history and neither is, nor can be, contradicted by any legitimate contrary regulatory interpretation.

The government urges a different "construction," which it refers to as the "book-balancing" view. What the government means by this label is *not* that, at the end of any fiscal period, the "books" must be retroactively "balanced" to ensure proper payments are made for that period under the *statutory* reasonable cost standard of § 1395x(v)(1)(A), *i.e.*, the form of reconciliation that petitioners assert clause (ii) unmistakenly requires. Instead, the government proposes that the books are to be mechanically balanced *only* to ensure that the "interim" payments made during the year (under a different section, § 1395g) are adjusted so that the total payment for the period conforms with the *regulatory* standards, even if those standards, as applied to a particular provider, do not produce payments equalling the statutory standard of reasonable costs as required by § 1395x(v). This view, which accomplishes only the first of the three steps required by clause (ii) and which by definition may leave providers under- or overpaid, is simply insupportable as an interpretation of clause (ii).

A. *The Secretary's Construction Of Clause (ii) Is Strained*

The Secretary points to essentially four aspects of the statutory language that she says supports her reading. These

efforts to fit her view into the text stretch any fair notion of textual interpretation well beyond the breaking point.

First, contrary to the Secretary's assertion (Gov't. Br. 16), nothing in the use of the term "retroactive" suggests that the adjustments are to be made only to conform interim payments to amounts due under the regulatory standards. Rather, that term merely indicates that it is at the end of the fiscal period that the comparison is to be made between amounts produced under the regulatory methods and the amount properly due under the reasonable cost standard set by the statute. Obviously, the last of the total costs "actually incurred" that comprise the reasonable costs of the provider for a fiscal period will not have been incurred until midnight of the last day of that period. Thus any comparison of interim payments against actual costs must necessarily await the close of the fiscal period and be a retrospective assessment.

Second, the phrase "corrective adjustments" as used in clause (ii) naturally refers to the adjustments needed to correct the discrepancy between the amount produced under the regulatory methods and the amount properly due under the reasonable cost standard set by the statute. Nothing about the term "corrective" limits corrections to "inaccuracies in the *application* of reimbursement methods prescribed by regulation." Gov't. Br. 16 (emphasis added). Nor does anything about the term "corrective" suggest that the adjustments must only be the "modest" corrections envisioned under the Secretary's interpretation. *Id.* Rather, "corrective" means "to fix what is wrong," whatever that takes.

Similarly, and contrary to the Secretary's half-hearted suggestion that the word "suitable" is a delegation of discretionary power not to make any adjustment (Gov't. Br. 18), a "suitable" adjustment is simply that adjustment which precisely eliminates the inadequacy or excess. This term gives the Secretary no license to deny adjustments to providers when

the very point of clause (ii) is to require case-specific adjustments for all individual providers that need them.

Third, the reference in clause (ii) to "aggregate reimbursement" strongly undermines, rather than supports, the Secretary's view. What clause (ii) demands to be judged "inadequate or excessive" is precisely the "aggregate reimbursement produced by the methods of determining costs"—that is, the "total" or "combined" reimbursement resulting from all of the "methods" considered together. The Secretary concedes that the term "methods" comprises all of the Secretary's regulations for determining reasonable cost. Gov't. Br. 17. Yet the Secretary then ignores that meaning and asks the Court to interpret clause (ii) to require that only the *partial* reimbursement produced by the interim payment mechanism, which is not even a "method" of determining reasonable cost, be analyzed for inadequacy or excess. How can "aggregate," a word meaning "total" or "combined," be construed to mean only partial reimbursement? This is especially so where nothing in the rest of § 1395x(v)(1)(A) suggests that the term "methods" means anything other than the *final* application of regulatory standards to determine total allowable costs.[1]

Fourth, clause (ii)'s "inadequate or excessive" test does not refer to the Secretary's regulatory cost limits as the benchmark for judging inadequacy or excessiveness. Gov't. Br. 17-18. As the Secretary concedes, it is the "statutory standard of reasonableness" that determines whether the "aggregate reimbursement" is inadequate or excessive. Gov't. Br. 17. And that standard, far from being "unspecified" (Gov't. Br. 17-18), has a statutory definition contained in the very same paragraph of § 1395x(v)(1)(A): "the costs actually incurred, excluding therefrom any part of incurred costs found to be unnecessary in the efficient delivery of needed health services."

[1] We disagree with the Secretary's assertion that our construction would "disaggregate" the analysis and permit a challenge to each and every method. Gov't. Br. 17. To the contrary, as even the Secretary argues, clause (ii) raises a "bottom line" issue, and that is what we have raised. The fact that the petitioners can point to one of the methods as the major culprit does not change the fact that our claim is that the bottom line reimbursement the petitioners received does not meet the standards set forth in the statutory definition of reasonable costs.

It is true that these costs "shall be determined in accordance with regulations" issued by the Secretary (Gov't. Br. 18), but Congress never intended this language to support the analysis the Secretary urges on the Court, a circular analysis from which there is no escape: *i.e.*, reasonable costs are to be determined by regulatory methods and, therefore, the only question is whether the costs are in accordance with the regulatory methods. Clause (ii) breaks that circle by providing for adjustments that meet the statutory standard *notwithstanding* the regulatory methods. Thus, the "regulations" must accomplish two tasks: (1) they must establish "methods" to be used in the first instance, and then (2) they must provide an adjustment mechanism when the methods produce inadequate or excessive reimbursement.[2]

The Secretary is not only unable to find support in the statutory language, but her argument runs directly counter to the text of clause (ii) and its relation to other provisions of the statute. Not a word in § 1395x(v)(1)(A) speaks of "interim" payments. This entire section is a definitional one; and the subsection at issue is concerned with the substantive entitlement of providers to "reasonable costs," not with the mechanism or timing of payments or audits. The latter question is

[2] Thus, in the absence of other regulations which provide for individualized adjustments for any provider where reimbursement under the regulations falls short of the statutory standard of actual, reasonable cost, the regulatory implementation of the authority to establish the Provider Reimbursement Review Board as a dispute resolution mechanism provides the procedures for the individualized corrective adjustments mandated by clause (ii). Pet. Br. 25-27. See p. 10, *infra*.

addressed in an entirely different provision, § 1395g.[3] If Congress had meant clause (ii) to be restricted to the task the government suggests, it could and surely would have referred to adjustments of the amount produced by the "interim payments under § 1395g." Instead, it required adjustments of the results of the "methods of determining costs"—which earlier sentences of § 1395x(v) make clear are the regulatory standards for reimbursement.

Similarly, Congress could easily have written clause (ii) to limit the required adjustments to those needed to conform payments to regulatory standards. It could have referred to "inaccuracies in the *application* of reimbursement methods prescribed by regulation" (Gov't. Br. 16) or to "aggregate reimbursement ultimately determined to be due to the provider *under* the regulations" (Gov't. Br. 16), or to the "aggregate amount actually found to be owing *under* the applicable methods prescribed" (Gov't. Br. 25), or to "correcting the results of the necessary inaccuracies involved in the interim cost estimation process" (Gov't. Br. 35), or to "'aggregate reimbursement' *within the framework* of the Secretary's reimbursement regulations" (Gov't. Br. 35 n. 23) (emphasis added in all quotes). Congress chose none of those expressions. Instead, Congress wrote clause (ii) plainly to require adjustments when the results of the regulatory methods themselves—the "aggregate reimbursement *produced by the methods of determining costs*"—prove too high or too low, necessarily using the statutory reasonable cost standard set out explicitly at the outset of the very paragraph of § 1395x(v)(1)(A) in which clause (ii) appears.

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[3] *See* pp. 8-9, *infra*.

B. The Legislative History Does Not Support The Secretary's Interpretation

The remarkable point about all of the Secretary's discussion of the legislative and regulatory history prior to the 1972 cost limits is how starkly it supports our view that the retroactive reconciliation contemplated by Congress in 1965 was adjustments to conform reimbursement to the *statutory* standard of actual reasonable cost, not just to the regulatory methods. The quotes cited by the Secretary from the Reimbursement Guidelines for Medicare: Hearing Before the Senate Comm. on Finance, 89th Cong., 2d. Sess. (1966), Gov't. Br. 23-25, with respect to congressional debate on the initial Medicare regulations, do indeed refer to retroactive adjustments. However, Congress considered the required reconciliation to be between interim payments and a provider's "actual costs," once those costs are known. For example, at these hearings the Chief Counsel to the Senate Finance Committee reviewed the legislative history on the enactment of Medicare, stating:

> . . .[W]hen they wrote their committee reports, they emphasized again that the reimbursement was to be for *actual cost*.

Id. at 95 (emphasis added). He also quoted the House report:

> In paying reasonable costs, it should be the policy of the insurance program to so reimburse a hospital or other provider that an accounting may be made at the end of each cost period for *costs actually incurred*.

Id. at 96 (emphasis added). He then said:

> [T]here is probably some flexibility in the legislative history that would permit an estimate to be made of some of these costs, provided that adjustments, retroactive adjustments, which are authorized by statute, would re-

> capture any excess payments, any payment *in excess of cost*, or would provide for payments to hospitals to make up any shortage in *costs*.

Id. at 96 (emphasis added). Nothing in these quotes supports the Secretary's contention that reconciliation was to be made only to the regulatory methods instead of to the statutory standard of actual reasonable cost.[4]

The Secretary's arguments concerning § 1395g, while creative, are also without merit. The fact that there was no mention of § 1395g in the original promulgation of the regulations, Gov't. Br. 26 n.14, is of no import, for that is the only section of the statute that authorizes the interim payment mechanism which the Secretary concedes is an integral part of the original regulations. *Id.* at 21. That the Secretary neglected to cite the proper statutory authority for the payment mechanism when the regulations were first published cannot override the plain meaning of the statute.[5]

Moreover, the phrase "with necessary adjustments on account of previously made overpayments or underpayments" in § 1395g can just as easily be read to include the final adjustments after audit to reconcile interim payments with the amounts due under the regulatory methods, rather than limiting the

[4] The quote from Commissioner Ball, Gov't. Br. 24 n. 13, as the Secretary implicitly acknowledges by her minimal reliance on the point, is naturally read to refer only to the retroactive alteration of *rules*, which is exactly what *Georgetown* held was impermissible, in express contrast to the individual retroactive case-by-case adjustments required by clause (ii).

[5] Nor is petitioners' view of § 1395g a belated one, as the Secretary suggests. Gov't. Br. 26. In 1973 the very first court of appeals to construe the meaning of clause (ii) agreed with the petitioners' view that the "book balancing" provisions cited by the Secretary were in fact authorized by § 1395g and did not implement the mandate of clause (ii). *Kingsbrook Jewish Medical Center v. Richardson*, 486 F.2d 663 (2d Cir. 1973).

language to interim and pre-audit adjustments, as the Secretary would construe it. Indeed, the Secretary even states that § 1395g can be construed to authorize the final retroactive "book balancing" adjustments she claims are authorized by clause (ii). Gov't. Br. 27 n.16. This admission undermines the rest of the Secretary's interpretation of the relevant legislative history.

The logical and natural construction of the statutory scheme is that § 1395g governs both interim payments *and* the audit to apply the regulatory methods, with its mechanical adjustments between the interim payments and amounts due under the regulations. Yet the Secretary insists on a construction under which all the mechanics for paying providers and auditing them, including the assessment of interest on final determinations of overpayments, are governed by § 1395g, except the final adjustment after audit. This final adjustment to reconcile interim payments with amounts due under the regulations, the Secretary contends, is governed by the reasonable cost "definition" section of the statute, *i.e.*, clause (ii). Such a strained interpretation clearly runs counter to the organization and structure of the statute.[6]

Finally, it is evident that when Congress enacted the authority for the cost limits in 1972, it did not change the statutory

[6] The Secretary's position is further belied by the fact that post-audit adjustments to reconcile interim payments with amounts due under the regulations continue to be made for certain hospitals that are paid on a prospective "per discharge" basis under § 1395ww(d), rather than on a reasonable cost basis under § 1395x(v)(1)(A). *See* Provider Reimbursement Manual § 2405.1.B ("The [interim] payments [based on total estimated discharges] will be reviewed...and subject to final settlement at year end based on a reconciliation to total payments as determined on a per discharge basis.") Obviously § 1395g is the authority for those final post-audit adjustments, for the language in § 1395g is not limited to payment of reasonable costs, and there is no other statutory provision authorizing such a final reconciliation for PPS payments.

right to a case-by-case adjustment to ensure compliance with the statutory standard of reasonable cost, for the language in clause (ii) did not change. At the same time, Congress elaborated upon the *statutory* standard of reasonable costs, by adding to statutory definition of "reasonable cost" in the first sentence of § 1395x(v)(1)(A) the phrase: "excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." It is against this standard that since 1972 clause (ii) requires aggregate reimbursement to be measured.

The legislative history of the 1972 amendments shows that Congress also created the Provider Reimbursement Review Board at that time because the Secretary had not provided an adequate remedy to providers with regard to claimed shortfalls in reimbursement. H.R. Rep. No. 231, 92d Cong., 2d Sess. (1972), *reprinted in* 1972 U.S.C.C.A.N. 4989, 5094; S.Rep. No. 1230, 92d Cong., 2d Sess. 51 (1972). Providing such a remedy as part of the 1972 legislation is consistent with (1) the further definition of reasonable cost to exclude costs "found" to be unnecessary in the efficient delivery of health care services; and (2) the delegation of authority to promulgate cost limits. *See* Pet. Br. 25-27.[7]

[7] Indeed the broadly worded jurisdictional grant of the Board in 42 U.S.C. § 1395oo(a) provides that a hearing may be obtained by a provider "if such provider is dissatisfied with a final determination of the organization serving as its fiscal intermediary . . . as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this title for the period covered by such report." That grant encompasses both a claim that the provider was under-reimbursed within the context of the Secretary's regulations and a claim that the reimbursement produced by the regulations themselves is inadequate. Had the 1972 Congress intended what the Secretary now contends clause (ii) means, it need only have provided for a hearing for any provider "dissatisfied with the final determination . . . of the total program reimbursement due to provider *under the Secretary's regulations*. . . ."

In her brief the Secretary effectively ignores the fact that Congress intended the cost limits to be just another "method" of determining reasonable cost, presumptive only, and subject to the overriding mandate of clause (ii) whenever this method, along with the others, results in inadequate or excessive reimbursement under the statutory standard. Thus, every provider, not just those few which fall within narrow exceptions provided by the Secretary, could obtain an adjustment if they could show their costs met the statutory standard of reasonable cost as expanded by the 1972 amendments. "Providers would of course have the right to obtain reconsideration of their classification for purposes of the cost limits applied to them and to obtain relief from the effect of the cost limits on the basis of evidence of the need for such an exception." S. Rep. No. 1230, 92d Cong., 2d Sess. 189 (1972).

C. Georgetown Supports The Petitioners

No less than four times did this Court in *Georgetown* construe the plain language of clause (ii) in the way that petitioners construe it, *i.e.*, as requiring case-by-case adjustments where the regulatory methods do not reach correct results in individual cases. *See* Pet. Br. 14-15.[8] The Court's reference to the Secretary's previously inconsistent interpretation of clause (ii), 488 U.S. at 211-12 and n.2, was not an endorsement of that interpretation. Rather, the Court cited the Secretary's "book balancing" regulations only as a reason not to defer to the Secretary's position in *Georgetown* that clause (ii) authorized retroactive rulemaking. Thus, *Georgetown* cannot be read as implicitly affirming the Secretary's interpretation put forth in this case.

The Secretary also asserts that the petitioners' construction of the statute violates *Georgetown* because any relief the

[8] The petitioners agree that retroactive case-by-case adjustments downward are allowable under clause (ii).

petitioners would obtain by means of individual retroactive corrective adjustments is tantamount to a wholesale change in the cost limits methodology and is therefore retroactive rulemaking. Gov't. Br. 35.[9] This position of the Secretary is absurd. The logical extension of the Secretary's conclusion is that regulations can never be found to be invalid as written or as applied in an individual appeal because such a holding ultimately would have the effect of retroactive rulemaking.[10]

Nor are the petitioners seeking a "second bite of the apple." Gov't. Br. 36. Rather, the statute offers two different avenues of redress to the petitioners: one is the right to challenge the validity of a regulatory method (*see* § 1395oo(f)(1)); the other is the right to an adjustment even where *valid* regulatory methods are invalid as applied in a particular situation, *i.e.*, where they do not reimburse actual reasonable cost (clause (ii)). Providers may seek relief under either one of these provisions, or under both.[11] The fact that petitioners now seek

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[9] The Secretary notes that petitioners asked for an 11% adjustment to the rural Nebraska wage index, which would result in an impermissible retroactive change to the cost limit "method" in violation of *Georgetown*. Gov't. Br. 35 n. 24. The petitioners did suggest, based on a study which analyzed the use of part-time employees in Nebraska vis-a-vis the rest of the country, that an 11% adjustment to the rural Nebraska wage index would be a "suitable" retroactive corrective adjustment for their situation. However, in the alternative, they asked the court of appeals for a remand to the PRRB to demonstrate that their costs in excess of the limits are reasonable. Pet. C.A. Rep. Br. 16-17.

[10] Such a result is directly contrary to the remedy granted for PRRB review of the application of regulations and judicial review of the validity of regulations in 42 U.S.C. § 1395oo.

[11] Indeed, had petitioners not also challenged the validity of the cost limits, the Secretary would be arguing that is what we should have challenged so that he could consider the merits of the regulations in the context of our challenge under clause (ii). *Association of American Medical Colleges v. Califano*, 569 F.2d 101 (D.C. Cir. 1977).

Moreover, the Medicare program's statutory obligation to pay providers the reasonable cost of caring for Medicare beneficiaries has not been

a clause (ii) adjustment where a valid regulatory method (the cost limits) produce inadequate reimbursement of their actual reasonable costs is not an impermissible "second bite."

The Secretary's threats of a floodgate of individual appeals should not persuade the Court to adopt the Secretary's narrow and strained reading of the statute. Clause (ii) is no longer applicable to many providers.[12] Moreover, not every provider

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negated simply because the use of "BLS data caus[ing] unavoidable distortions" has been sustained as "the best [data] source currently available" for constructing a national wage index. The burden of proof falls on the provider—or the government—to show under clause (ii) how aggregate reimbursement—for whatever cause—is inadequate or excessive in an individual instance.

This function served by clause (ii), *i.e.*, individualized adjustments, has long been recognized as central to a workable regulatory scheme. For example, in *United States v. Storer Broadcasting Co.*, 351 U.S. 192, 205 (1956), this Court upheld a regulation limiting any applicant for a broadcasting license to an interest in a maximum number of stations. The necessary flexibility, the Court found, was provided through the availability of a full hearing for individual applicants that might show why, in their case, the rule should be waived or amended. Again, in *FPC v. Texaco, Inc.*, 377 U.S. 33, 41, (1964), this Court upheld a regulation barring from consideration for a certificate of public convenience and necessity any natural gas supplier that included certain price clauses in its contracts with pipeline companies. As in *Storer*, the Court found determinative the opportunity afforded individual regulated entities to show that the rule was invalid as applied in its case. *See also Pacific Gas & Electric Co. v. FPC*, 506 F.2d 33, 38 (D.C. Cir. 1974).

[12] Most hospitals are now paid under the prospective payment system, 42 U.S.C. § 1395ww(d), rather than under the reasonable cost methodology with its clause (ii) adjustment. Although certain specialty hospitals exempt from PPS (*e.g.*, rehabilitation, psychiatric) continue to be paid on the basis of reasonable costs, their reimbursement is subject to an absolute per discharge limit under 42 U.S.C. § 1395ww(b) which is not subject to a clause (ii) adjustment. A third of Medicare skilled nursing facilities are reimbursed under a prospective payment methodology rather than the reasonable cost method. *See* 42 U.S.C. § 1395yy(d). Although

to which clause (ii) applies can show that its costs in excess of the limits are reasonable. Only in situations such as this, where the underpayment is substantial enough to warrant the time and expense of litigation and where the provider believes it can meet the burden of proof by demonstrating that its actual costs are not "unnecessary in the efficient delivery of needed health services," would a provider consider undertaking the task. A provider is not likely to initiate such an appeal lightly. *See* Amicus Br. 26-28. Further, no argument of administrative burden can overcome the right to an adjustment granted by the plain language of the statute. *EEOC v. Associated Dry Goods Corp.*, 449 U.S. 590, 604-605 (1981).

D. The Secretary's Position Deserves No Deference

In this case there is clearly no basis for deference. "[A] pure question of statutory construction [is] for the courts to decide." *INS v. Cardoza - Fonseca*, 480 U.S. 421, 446 (1987). *See also Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43 and n.9 (1984). Where the statutory language is unambiguous, courts cannot defer to a contrary agency interpretation. *Pittston Coal Group v. Sebbin*, 109 S. Ct. 414, 420 (1988).

The Secretary offers nothing but excuses for its concededly shifting positions on what clause (ii) means, all designed to escape the plain meaning of the statute. The alleged "disarray" in the lower courts did not cause the Secretary's inconsistency.[13] Neither Congress nor the courts ordered the Sec-

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home health agencies are still cost reimbursed, they generally are relatively small providers that cannot afford to pursue such appeals.

[13] It is misleading for the Secretary to imply that *Mt. Sinai Hospital of Greater Miami, Inc. v. Weinberger*, 376 F.Supp. 1099 (S.D. Fla. 1974), *rev'd*, 517 F.2d 329 (5th Cir. 1975), *cert. denied*, 425 U.S. 935 (1976), supports the bookbalancing view espoused by the Secretary in this case, *i.e.*, that § 1395g only authorizes pre-audit adjustments while clause (ii) is the authority for post-audit final adjustments. Gov't. Br. 38. The issue in *Mt. Sinai* was whether § 1395g authorized adjustments for overpayments due to *coverage* denials. Significantly, it was the Secretary who, in 1972, invoked § 1395g as authority for suspending payments to providers when final audits indicated there were overpayments due to coverage determinations. 376 F. Supp. at 1127. The district court and court of appeals rejected the Secretary's position and construed § 1395g and clause (ii) together to conclude that those provisions related to *cost* determinations rather than coverage determinations. But the courts did not in any way adopt the dichotomy that § 1395g relates only to pre-audit adjustments while clause (ii) authorizes the final adjustment after audit.

retary to take inconsistent but convenient litigating positions. Rather, the inconsistency in the Secretary's positions demonstrates that the Secretary feels free to ascribe to language a meaning that is convenient to whatever issue the Secretary is litigating at the time. This case is no exception.

Finally, the cases cited by the Secretary for the proposition that a contemporaneous interpretation of a statute by the agency charged with its implementation is entitled to great weight, Gov't. Br. 22, are inapposite here, for implicit in those cases is the assumption that the agency's position has been consistent.[14] Where, as here, the agency's construction changes over time to suit its immediate needs, and where it is inconsistent with the plain language of the statute, no deference should be given. *EEOC v. Arabian American Oil Co.*, 111 S. Ct. 1227, 1235 (1991); *National Muffler Dealers Ass'n, Inc. v. U.S.*, 440 U.S. 472, 477 (1979); *Southeastern Community College v. Davis*, 442 U.S. 379, 411-12 and n. 11 (1979); *Morton v. Ruiz*, 415 U.S. 199, 238 (1974).

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[14] In *Red Lion Broadcasting Co. v. FCC*, 395 U.S. 367, 382 (1969), the Court explicitly referred to 30 years of consistent agency interpretation.

CONCLUSION

For the foregoing reasons, the petitioners request that the decision of the court of appeals be reversed and that this case be remanded to the Provider Reimbursement Review Board where the petitioners shall have the opportunity to demonstrate that their costs in excess of the cost limits are reasonable.

Respectfully submitted,

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